Medical Billing Advocacy Application

INSTRUCTIONS: Please complete this application form in its entirety and submit it along with the documents described below.

■ Patient's Information

This is the person who received the medical care that the bills are for.

Name (Last, First, Middle): _____

Address: _____ Apartment: _____

City: _____ State: _____ ZIP: _____

Cell: _____ Home: _____ Email: _____

■ Applicant's Information

If same as Patient, check this box ☐ *and skip to the next section. If not same as Patient, this shall be the contact person.*

Name (Last, First, Middle): _____

Address: _____ Apartment: _____

City: _____ State: _____ ZIP: _____

Relationship to Patient: _____

Cell: _____ Home: _____ Email: _____

■ Desired Services

Please put a check mark next to all the services you wish to retain:

- ☐ To review my medical bills and explain them to me. *(Available for an hourly fee.)*
- ☐ To negotiate with my creditors for a reduction in my financial responsibility. *(Available on commission.)*

■ Supporting Documentation

- Copies of all medical bills you wish us to review.
- If you are not the patient, copies of documentation establishing your right to act on the patient's behalf. (Examples include power of attorney, proof you are executor of the patient's estate, or similar documentation. Parents may submit the child's birth certificate or adoption certificate and the parent's ID which corresponds to the one the certificate.)

SUBMITTING THIS APPLICATION DOES NOT CREATE ANY CONTRACTUAL OR OTHER RELATIONSHIP BETWEEN YOU AND CLEAN BILL OF HEALTH, LLC.